Cindy Duggin, LLC
706 North 129th Street, Suite 103
Omaha, NE 68116
(402) 991-1495

New Client Information

Please complete all information and sign and date. Bring all forms to your first appointment.

Date: _____ Referred by: _____

Name: _____Date of Birth: _____Age: _____

Social Security Number: _____

Address: _____

City, State, Zip: _____

Tel. Cell _____ Home _____ Work _____

EMAIL: _____

Where do you prefer to receive calls? Home _____ Work _____ Cell _____

Is it ok to leave a detailed message? Home _____ Work _____ Cell _____

Employer: _____

Occupation: _____

Emergency Contact: _____Relationship to you _____

Tel. _____ Alternate Tel. _____

FEES
$230.00 for initial evaluation.
$205.00 for 60 minute session
$130.00 for 45 minute session
$100.00 for 30 minute session
$145.00 for family session
$ 50.00 fee for missed appointments and late cancellations

Authorization to Communicate with Primary Care Physician (PCP)

_____ I **do not** give permission to contact my PCP

_____ I **do** give my permission to contact my PCP

PCP Name/Location/Telephone: _____

Authorizations and Concents

Authorization for Filing Insurance

I authorize the release of any medical or personal information required to process insurance claims. I authorize the payment of medical benefits to Cindy Duggin LLC. If I request services not covered by my insurance company, I agree to pay in full at the time of the service. I will be told in advance if services may not be covered (i.e. longer than 60 minutes, or because I am not a provider for your health insurance company). I will not be charged for brief, under 15 minute telephone calls, but if I request longer sessions by telephone, I understand that these are generally not covered by insurance, and agree to pay these charges in full.

Fee for late cancellation or missed appointments

I agree to cancel appointments at least 24 hours before my scheduled appointment. If I do not give twenty-four-hour notice and another client does not fill my appointment time, I understand that I will be charged a $50.00 fee for missed or late canceled appointments. Sudden illness or family emergencies will be given due consideration on a case-by-case basis. I understand that insurance companies do not usually cover fees for late cancellations or missed appointments.

Consents

I acknowledge having been offered copies of:

1. Notice of Privacy Policies for Cindy Duggin, LLC.
2. This signed agreement.
3. Service Agreement, including informed consent

Consent for me or my dependent to be treated

I give my legal and informed consent for myself or my dependent to be evaluated and treated by Cindy Duggin, LICSW.

Printed Name(s)_____

Dependent Name (s) _____

Additional Participants_____

Signature of Client/Guardian_____Date_____
If not the client, please state your relationship to the client: _____